Alliance Physio

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## Patient Personal Information

| | |
|---|---|
| **Name** | **DOB** |
| **Address** | **Post Code** |
| **Phone Number** | **Family Dr.** |
| **Occupation** | **Referred by** |

**What brings you here today?**

**Co-morbidities (if applicable):**

| | |
|---|---|
| Cerebrovascular accident☐ | Diabetes Mellitus☐ |
| Hypertension☐ | Anemia☐ |
| Colitis☐ | Coronary atherosclerotic heart disease☐ |
| Hepatitis☐ | Tuberculosis☐ |
| Depression/Anxiety☐ | Chronic Fatigue Syndrome☐ |
| Fibromyalgia☐ | Multiple sclerosis☐ |
| Parkinson's Disease☐ | Transient Ischemic Attack☐ |
| Lumbar Disc Herniation☐ | Eczema☐ |

Others:

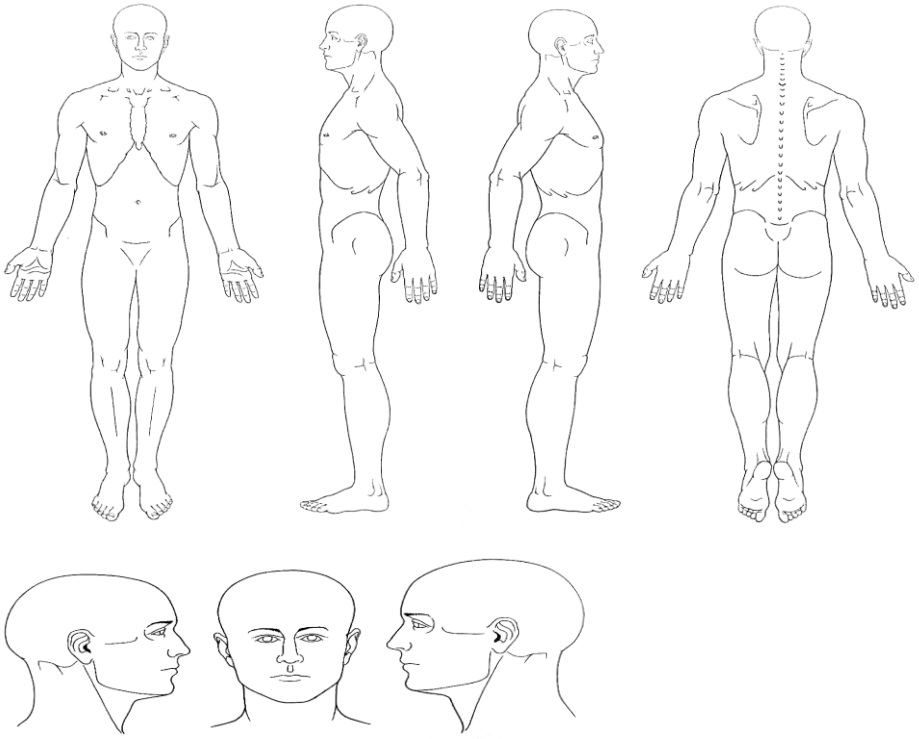
**What has been diagnosed & what treatments have been applied (if available):**

**Surgery history (if applicable):**

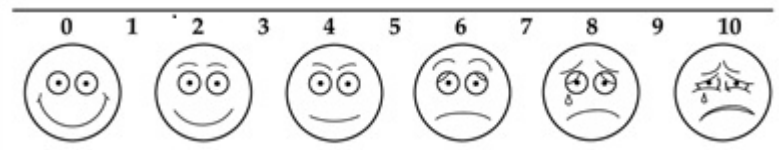
**Allergies (if applicable):**

**Medicines undertaken currently or in the last 6 months (if applicable):**

**Circle the painful or uncomfortable area:**



**Pick a score from 0-10 for Pain/Depression/Anxiety:**




**0 = no pain/depression/anxiety**

**5 = moderate pain/depression/anxiety**

**10 = worst pain/depression/anxiety**

**Chief complaints:**

**History of present illness (***Energy, Sleep, Appetite, Thirst, Sweating, Chills/Fever, Body Pains, Bowels, Urine, Menstruation***) & Body checkup:**

**Tongue:**

Shape*: thin, swollen, teeth mark;* Color*: pale, red, purple;* Coating*: white, yellow, dry, greasy, others* **Other**

**Pulse: (Left) (Right)**

*Floating, Deep, Slow, Rapid, Deficient, Excessive, Slippery, Choppy, Wiry, Weak*

## Female:

Childbearing History: Cesarean section: Yes / No

Last period: Pregnant currently: Yes / No

Other:

## TCM Diagnosis/ differentiations:

## Treatment principal:

## Acupuncture Points Prescribed:

**Practitioner Signature: _____ Date: _____**